High Deductible Health Plans

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Background

- High deductible health plans (HDHPs) are characterized by:
  - Lower premiums than traditional insurance policies
  - A higher annual deductible than typical health plans (minimum annual deductible of $1,200 for single and $2,400 for family coverage in 2012; average deductible is often much higher)
  - A maximum limit on the sum of the deductible and out-of-pocket expenses (maximum out-of-pocket spending of $6,050 for single and $12,100 for family coverage in 2012)
  - A paired tax-free Health Savings Account (HSA) or Health Reimbursement Arrangements (HRA)

Health Savings Accounts

- Established under Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Contributions by an individual or an employer are tax deductible (maximum contribution of $3,100 for single coverage and $6,250 for family coverage in 2012)
- Contributions by an employer may be excluded from an individual's gross income
- Contributions roll over and earn interest tax-free
- Belong to individual, not employer; portable

Purported Advantages of HDHPs

- Increase sensitivity to cost of care, creating more cost-conscious consumers; resulting in:
  - Less unnecessary care, decreasing spending overall
  - Health services market more like markets for other goods/services, lowering costs and improving quality
- Lower premiums allow individuals/companies to afford to continue or initiate coverage, draw uninsured individuals into market
- Allows insurance carriers to offer more options, increasing market competition and health

Purported Disadvantages of HDHPs

- Limited ability to reduce system wide spending
  - Small proportion of population accounts for large share of total spending, highest users unlikely to have HDHPs
  - Incentives to eliminate unnecessary use/seek lower prices operate primarily for spending below deductible, not where most of spending occurs
- Adverse selection
  - HDHPs more attractive to healthier individuals, leaving less healthy pool of individuals in typical plans

Purported Disadvantages (continued)

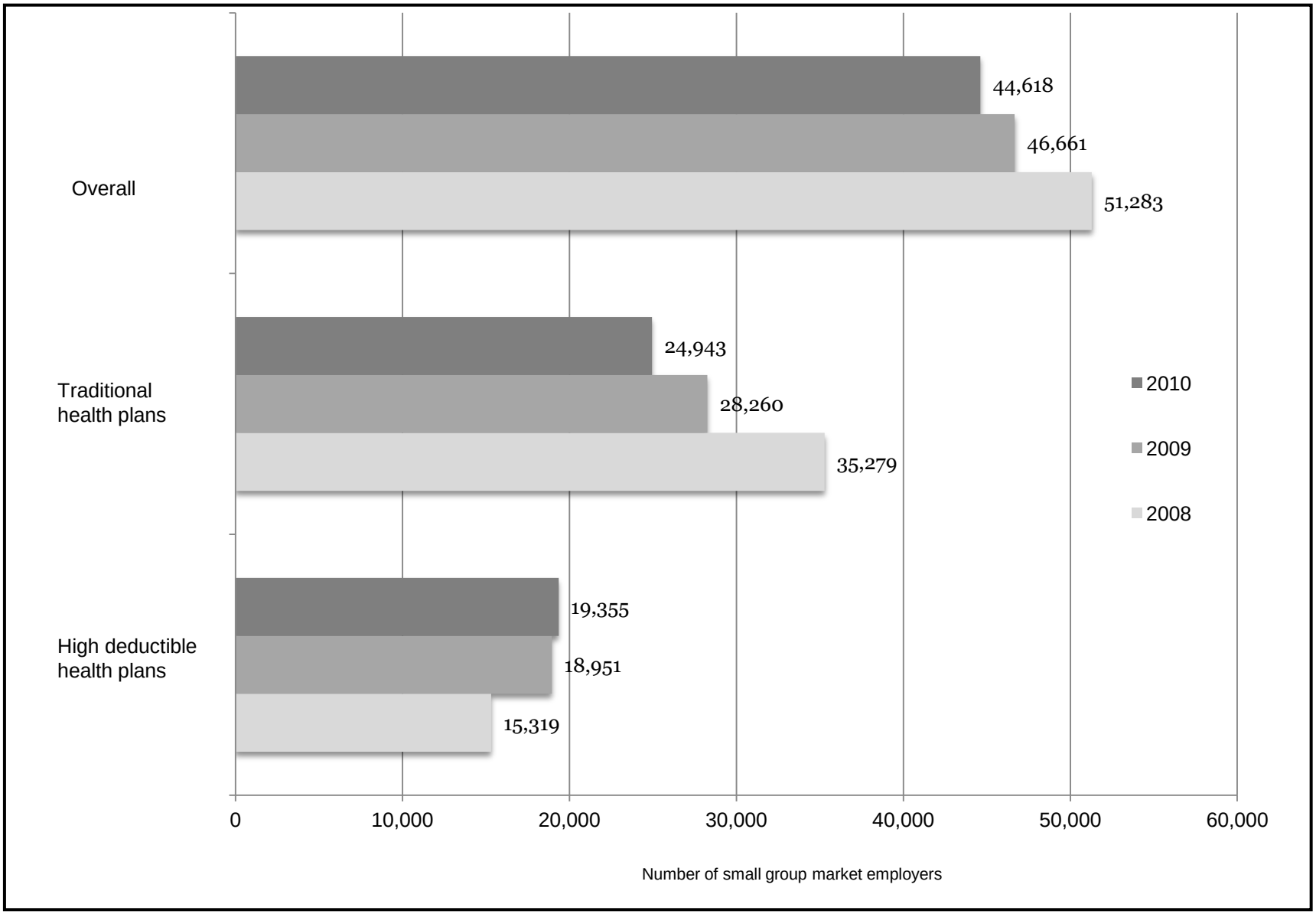
- Individuals may avoid, skip, delay health care
  - Reductions in spending may be result of foregoing preventive services, necessary care – may lead to more medical problems and increased costs long term
- Difficult for consumers to “shop around,” lack of needed information on costs/quality of care

Summary of Evidence

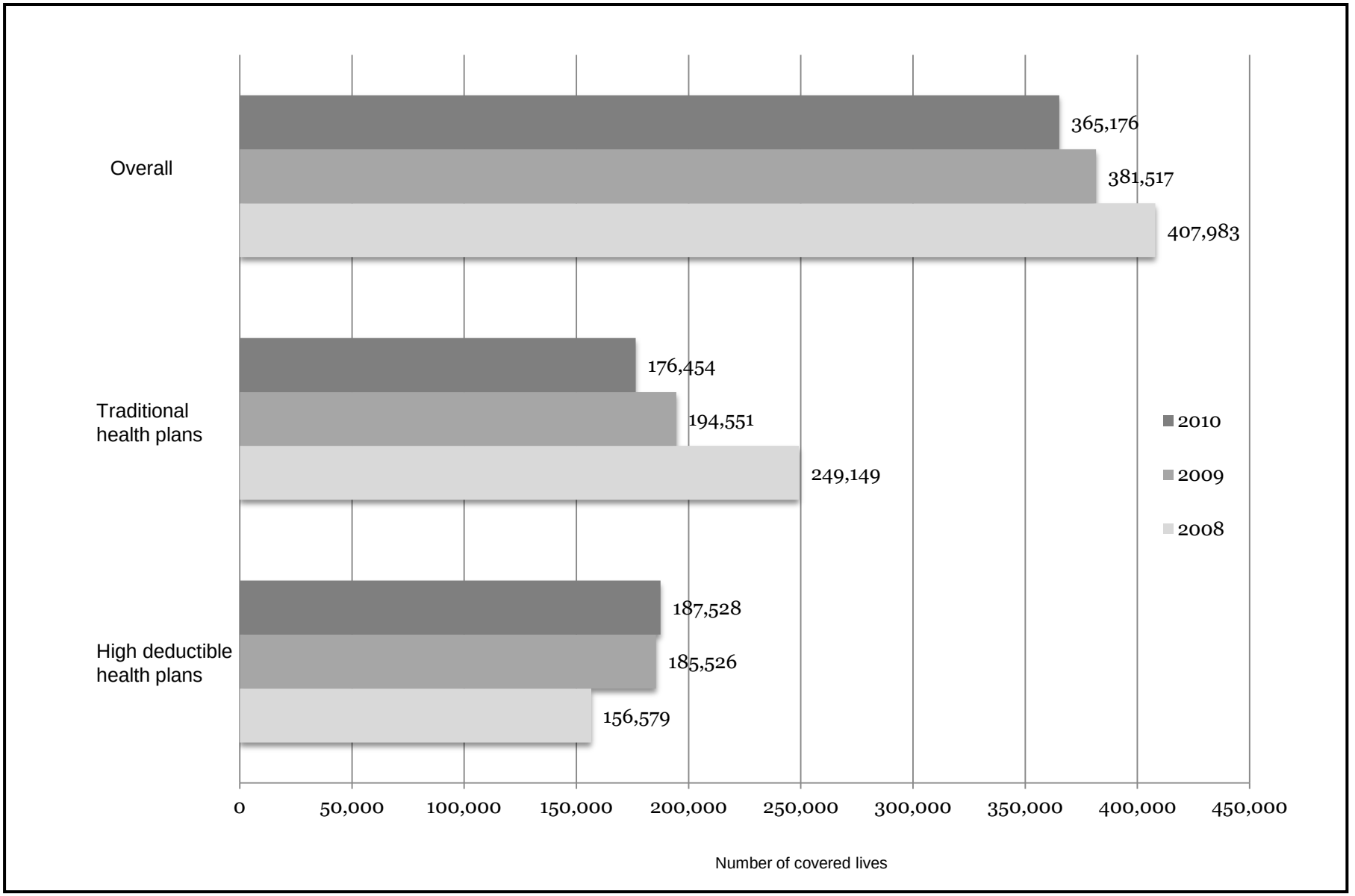
- HDHPs associated with reduced total health care use and spending, lower rates of increase in costs or use
  - Effect is moderated by generous employer contributions to HSAs
- Evidence mixed re reductions in use for “necessary” vs. “unnecessary” care

Buntin, Damberg, Haviland, et al., 2006; Buntin, Haviland, McDevitt, & Sood, 2011; Galbraith, A. A., Soumerai, S. B., Ross-Degnan, D., et al., 2012

Trends in use of HDHPs in Maryland: Number of small group market employers offering health coverage by plan type, 2008-2010



Trends in use of HDHPs in Maryland: Number of covered lives by plan type, 2008-2010



Impact of the ACA

- Preventive care must be covered at 100%
- Exchanges
  - HDHPs will most likely fall within the bronze (60% actuarial value) level
  - Subsidies available to offset premiums and cost-sharing for low-income individuals but only in individual market; in small group market, will be tax credits for employers but no subsidies for individuals
- Overall, unclear how much of an impact ACA will have on HDHPs

Recommendations

- Track impact of HDHPs on access to care and costs
  - Employer contributions to HSAs
  - Health of individuals in HDHPs vs traditional plans, potential increases in HDHP premiums
  - Coverage and use of preventive services

Recommendations (continued)

- Explore options including:
  - Reduced deductibles for lower-income individuals
  - Exempting effective services/medications for individuals with chronic health care conditions
  - Providing information on costs and quality of care